Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ C B. WING IL6014195 02/19/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH WEILAND ROAD SYMPHONY OF BUFFALO GROVE **BUFFALO GROVE, IL 60089** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 000 Initial Comments \$ 000 Facility Reported Incidenct of 2/7/20/IL120207 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary b) care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care Attachment A plan. Adequate and properly supervised nursing Statement of Licensure Violations care and personal care shall be provided to each resident to meet the total nursing and personal

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

TITLE

(X6) DATE 03/06/20

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6014195	B. WING		02/1	9/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
SYMPHONY OF BUFFALO GROVE 150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089					
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PRINTED: 04/20/2020 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B WING IL6014195 02/19/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH WEILAND ROAD SYMPHONY OF BUFFALO GROVE **BUFFALO GROVE, IL 60089** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION m (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 2 S9999 Cerebrovascular Disease, Weakness, Reduced Mobility, Fracture of Nasal Bones. R1's Minimum Data Set dated September 30. 2019 Brief Interview for Mental Status shows. 99-Resident was unable to complete interview. R1's Progress Notes dated 2/7/2020 at 10:09PM, by V10 LPN-Licensed Practical Nurse shows: While I was in the nursing station, I heard an impact that sounded like somebody fell. As soon as I looked at the hallway, I saw CNA (Certified Nursing Assistant) by the wheelchair and observed R1 already on the floor. I went to assess, while resident remained on the floor and noticed residents face bleeding. I called for help and the other nurse came over and stayed with resident while I called 911. The Paramedics came and took R1 to ER-Emergency Room. R1's Progress Notes dated 2/7/2020 at 10:09PM, by V10 LPN shows, report from ER-Emergency Room, R1 is admitted (to the hospital) with the diagnosis of facial trauma, closed fracture of nasal bone and forehead laceration. The facility's Incident Report dated 02/07/2020 at 7:00PM, shows, R1 is an 85 year-old female that resides on our Dementia Unit. Resident is alert to self at times with confusion. She uses her wheelchair for locomotion on the unit, she can self-propel with direction from staff. R1 has impaired cognition due to Dementia disease

hallway rail.

process but is usually redirectable. The facility investigation interviews showed R1's CNA reports that prior to incident, she was noted at times reaching out and attempting to grab onto the

On 2/19/2020 at 11:58AM, V8 CNA-Certified

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The facility's Wheelchair Leg/Footrests policy dated September 2016 shows: Wheelchair leg rests are extremely important to any resident who uses a wheelchair as they assist the resident in

sitting up in the optimum sitting position. improving posture, and promoting better blood circulation. Guideline: Therapy and or Restorative

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